

Michigan Medical Marihuana Program

Application/Renewal Instructions and Checklist

www.michigan.gov/mmp (517) 284-6400

Michigan Medical Marihuana Program

Application for Registry Identification Card

FOR MINOR APPLICANTS ONLY

Instructions

- This application is for a person who is under 18 years of age and a resident of Michigan.
- Type or print legibly when completing the application.
- The original signed Application Form and both Physician Certification Forms must be submitted to the MMMP.
- Keep a copy of all documents submitted for your records.
- Make checks or money orders payable to: **State of Michigan-MMMP.**
- Do not include other forms, fees, or documentation in the envelope.
- Mail only one complete application and all required documentation (see below) in one envelope to:

Michigan Medical Marihuana Program P.O. Box 30083 Lansing, MI 48909

Checklist

Minor Application Form for Registry Identification Card

 Any use of white-out on or alterations to the Minor Application Form will result in the denial of your application.

Minor Application Fee: \$85 (\$60 patient fee and \$25 caregiver fee required)

Proof of Michigan Residency

- Parent or legal guardian must a submit copy of his or her valid Michigan driver license or personal identification card.
- If the minor patient has a valid Michigan driver license or personal identification card, please submit a copy with the application.
- The copies must be clear and legible.

Copy of proof of parentage or legal guardianship (i.e., birth certificate, court order, etc.)

Two Physician Certification Forms

- Two Physician Certification Forms must be completed and signed by two separate physicians. Each physician must be a medical doctor or doctor of osteopathic medicine and surgery who holds a current license to practice in the State of Michigan.
- Any use of white-out on or alterations to either Physician Certification Form will result in the denial of your application.

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\$85 Application Fee Received

Application Form for Registry Identification Card MINOR APPLICANTS ONLY

Castian A. Patiant Information (see a second				· /DEQLUE	250)
Section A: Patient Information (NAME AS IT APPEARS					•
1Legal First Name	2.Middle In	itial	3a. Legal Las	st Name	3b. Suffix (Jr., Sr., etc.)
4. Patient Registry ID Card Number (For Renewals Only)	5. Date	of Birt	h (MM/DD/YYY	Y)	
P					
Co. Mailing Address					
6a. Mailing Address					6b. Apartment/Suite/Lot#
7. City		8. Sta	ate	9. Zip Co	de
		ſ	MI		
10 Talanhana Number (antional)					
10. Telephone Number (optional)					
The parent or legal guardian liste	d in Se	ctio	n C mus	st serv	e as the patient's
					·
caregiver and possess the minor	patient	L S 11	ieuicai i	mariiii	ualia pialits.
Section C: Parent or Legal Guardian Information (NAME AS IT	VDDEV	PS ON ID) /R	FOLURED	1
11. Legal First Name			13a. Legal La		13b. Suffix (Jr., Sr., etc.)
11. Legar instrume	12. Wildaic	initiai	13a. Legai Le	35t IVallic	130.30.111.(31.) 51.) 616.)
14. Caregiver Registry Card ID Number (For Renewals Onl	y) 15. Dat	e of Bir	rth (MM/DD/YY	YY)	16.Gender (used for conviction history
C					only) Male Female
17a. Mailing Address					17b. Apartment/Suite/Lot#
17 d. Walling Address					17b. Apartment/Suite/Lot#
18. City		19. St	tate	20. Zip C	ode
			MI		
21. Telephone Number (optional)					
21. relephone Number (optional)					
22. Other Names Used by Parent or Legal Guardian (Nick	names, mai	den na	mes etc. Use	a separate	e piece of paper if you need more space.)
Section D: Parent/Legal Guardian Signature & Date (REQUIRED))			
I attest the information I provided is true and accurate a	nd that I wi	ill comp	oly with the r	equireme	nts of the Michigan Medical
Marihuana Act (Initiated Law 1 of 2008, MCL 333.26422					
years old, have no felony convictions that disqualify me					
the information provided in this application to perform				understa	nd that falsified or fraudulent
information may be reported to law enforcement and resu	iit in crimina	ıı prose	cution.		
Signature of Parent/Legal Guardian:					Date:

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Declaration of Person Responsible for MINOR Patient

DECLARATION BY PARENT OR LEGAL GUARDIAN (REQUIRED)

To be signed and completed by patient's parent or legal guardian

This Declaration of Person Responsible form must be completed and submitted with the MINOR application packet. Only the parent or legal guardian can serve as the primary caregiver for a minor patient. A copy of proof of parentage or legal guardianship (i.e. birth certificate or court order, etc.) must be submitted with a Minor Application or the application will be denied.

I declare each of the below statements is true and accurate:

- The patient's physicians have explained to the patient and me the potential risks and benefits of the medical use of marihuana.
- I consent to the patient's medical use of marihuana.

 I agree to serve as the patient's designated caregiver. I agree to control the acquisition, dosage, and frequency of the medical use of the marihuana by the patient.
Section E: Parent or Legal Guardian Declaration: (REQUIRED)
I attest the information provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 <i>et seq.</i>) and associated administrative rules. I understand that falsified or fraudulent information may be reported to law enforcement and result in criminal prosecution.
Signature of Parent/Legal Guardian: X

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Physician Certification Form #1 for Minor Patient

This certification must be completed and signed by a <u>medical doctor or doctor of osteopathic medicine and surgery who holds an</u> active license to practice in the State of Michigan.

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Section A: Certifying Physician Infor	mation(AS IT APPEARS		D)
1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., etc.)
4a. Full Mailing Address		4b.	Apartment/Suite/Lot #
5. City 6	. State 7. Zip Code	3	3. Telephone Number
O Mishissa Bhasisisa Lisasa Nasaha da			
9. Michigan Physician License Number (e		D 0	
M.D		D.O	
Section B: Patient Information (NAM	E AS IT APPEARS ON ID O		DOCUMENTS) (REQUIRED)
10. Legal First Name	11. Middle Initial	12a. Legal Last Name	e 12b. Suffix (Jr., Sr., etc.
13. Date of Birth (MM/DD/YYYY)			
Section C: Patient's Debilitating Me	dical Condition(s)/RF	OUIRFD)	
This patient has been diagno			cal condition(s):
(A minimum of one box mu	ust be checked in at le	east one of the follow	ing categories.)
Category A	Category B		Category C
Cancer	A chronic or debilita		Post Traumatic Stress Disorder
Glaucoma	medical condition of produces 1 or more		
HIV Positive or AIDS	Cachexia or Was		Other medical condition approved by
Hepatitis C	Severe and Chro	• .	the Medical Marihuana Review Panel:
Amyotrophic Lateral Sclerosis	Severe Nausea	THE FAIR	
Crohn's Disease		ing but not limited	
Agitation of Alzheimer's Disease		eristic of epilepsy.)	
Nail Patella	Severe and Pers		
	those characteri	ng but not limited to stic of multiple	
	sclerosis.)		
Section D: Certification, Signature, a	•	•	
Medical Marihuana Act and associated adm	ninistrative rules and have	e a bona fide physician-p	e. I attest that I am in compliance with the Michigan atient relationship with this patient. I attest that I
			condition, including a relevant, in-person, medical therapeutic or palliative benefit from the medical
use of marihuana to treat or alleviate the o			



Physician Certification Form #2 for Minor Patient

This certification must be completed and signed by a <u>medical doctor or doctor of osteopathic medicine and surgery who holds an</u> active license to practice in the State of Michigan.

Section A: Certifying Physician Infor	mation	(AS IT APPEARS	ON LICENSE) (REQUIR	ED)	
1. Legal First Name		Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., etc.)	
4a. Full Mailing Address			4b. Apartment/Suite/Lot #		
5. City 6	S. State	7. Zip Code		8. Telephone Number	
O Michigan Dhasisian Lineara Namban /	10	4:-:4 I-A			
9. Michigan Physician License Number (aigits only)	5.0		
M.D	· – –	_	D.O		
Section B: Patient Information (NAM					
10. Legal First Name	1	1. Middle Initial	12a. Legal Last Name	12b. Suffix (Jr., Sr., etc.)	
13. Date of Birth (MM/DD/YYYY)					
Section C: Patient's Debilitating Me	edical Co	ondition(s) <i>(RF</i>	(OUIRED)		
This patient has been diagnost				al condition(s):	
(A minimum of one box mus	be che	cked in at least	one of the followin	g categories.)	
		_			
Category A	Categ	ory B		Category C	
Category A Cancer	A chr	onic or debilita		Post Traumatic Stress Disorder	
	A chro	onic or debilita	its treatment that		
Cancer	A chro medio produ	onic or debilita	its treatment that of the following:		
Cancer Glaucoma	A chromedic produ	onic or debilita cal condition or uces 1 or more	its treatment that of the following:	Post Traumatic Stress Disorder	
Cancer Glaucoma HIV Positive or AIDS	A chromedic produ	onic or debilita cal condition or uces 1 or more uchexia or Wast	its treatment that of the following:	Post Traumatic Stress Disorder Other medical condition approved by	
Cancer Glaucoma HIV Positive or AIDS Hepatitis C	A chromedic medic produ Ca Se	onic or debilitated cal condition or uces 1 or more achexia or Wastevere and Chronovere Nausea	its treatment that of the following:	Post Traumatic Stress Disorder Other medical condition approved by	
Cancer Glaucoma HIV Positive or AIDS Hepatitis C Amyotrophic Lateral Sclerosis	A chromedic produ	onic or debilitated cal condition or debilitated condition or decension or Wastevere and Chronovere Nausea	its treatment that of the following: ing Syndrome nic Pain	Post Traumatic Stress Disorder Other medical condition approved by	
Cancer Glaucoma HIV Positive or AIDS Hepatitis C Amyotrophic Lateral Sclerosis Crohn's Disease	A chromedic produ	onic or debilitated cal condition or design or more access 1 or more access 1 or waste overe and Chrone overe Nausea eizures (Includitations) those characters and Persis	rits treatment that of the following: ing Syndrome nic Pain ng but not limited eristic of epilepsy.) stent Muscle	Post Traumatic Stress Disorder Other medical condition approved by	
Cancer Glaucoma HIV Positive or AIDS Hepatitis C Amyotrophic Lateral Sclerosis Crohn's Disease Agitation of Alzheimer's Disease	A chromedic produ	onic or debilitation of cal condition or desired and chexia or Wast evere and Chron vere Nausea eizures (Including those characters and Persistens) those characters those characters of those characters and characters of those characters and control of those characters are control of those characters and control of those characters are control of those characters and control of those characters are control of the co	rits treatment that of the following: ing Syndrome nic Pain ng but not limited eristic of epilepsy.)	Post Traumatic Stress Disorder Other medical condition approved by	
Cancer Glaucoma HIV Positive or AIDS Hepatitis C Amyotrophic Lateral Sclerosis Crohn's Disease Agitation of Alzheimer's Disease Nail Patella	A chromedic produ	onic or debilitation of cal condition of decension of the condition of the	rits treatment that of the following: ing Syndrome nic Pain ng but not limited eristic of epilepsy.) stent Muscle g but not limited	Post Traumatic Stress Disorder Other medical condition approved by	
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Cancer Glaucoma HIV Positive or AIDS Hepatitis C Amyotrophic Lateral Sclerosis Crohn's Disease Agitation of Alzheimer's Disease Nail Patella Section D: Certification, Signature, a By signing below, I attest that the informat Medical Marihuana Act and associated adri	A chromedic production of the	onic or debilitation of cal condition or desiling of calculation o	rits treatment that of the following: ing Syndrome nic Pain ng but not limited eristic of epilepsy.) stent Muscle g but not limited eristic of multiple eristic of multiple	Post Traumatic Stress Disorder Other medical condition approved by the Medical Marihuana Review Panel:	
Cancer Glaucoma HIV Positive or AIDS Hepatitis C Amyotrophic Lateral Sclerosis Crohn's Disease Agitation of Alzheimer's Disease Nail Patella Section D: Certification, Signature, a By signing below, I attest that the informat Medical Marihuana Act and associated adhave completed a full assessment of the	A chromedic production of the production of the patient's patient'	onic or debilitation of cal condition or decession or more accession or waste overe and Chrone of those characters (Including those characters (Including those characters) of the characters (Including those charac	rits treatment that of the following: ing Syndrome nic Pain ng but not limited eristic of epilepsy.) stent Muscle g but not limited eristic of multiple eristic of multiple eristic of multiple eristic not strue and accurate a bona-fide physiciand and current medical	Post Traumatic Stress Disorder Other medical condition approved by the Medical Marihuana Review Panel:	
Cancer Glaucoma HIV Positive or AIDS Hepatitis C Amyotrophic Lateral Sclerosis Crohn's Disease Agitation of Alzheimer's Disease Nail Patella Section D: Certification, Signature, a By signing below, I attest that the informat Medical Marihuana Act and associated adrhave completed a full assessment of the evaluation. Further, I attest that in my pro-	A chromedic production of the production of the patient's ofessional and production of the patient's ofessional and patie	onic or debilitation of cal condition or decession or more accession or waste overe and Chrone of those characters (Including those characters) of those characters (Including those characters) of the control of the c	rits treatment that of the following: ing Syndrome nic Pain ng but not limited eristic of epilepsy.) stent Muscle g but not limited eristic of multiple eristic of multiple eristic of multiple eristic not strue and accurate a bona-fide physiciand and current medical tient is likely to receive	Post Traumatic Stress Disorder Other medical condition approved by the Medical Marihuana Review Panel:	

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